



**ARIZONA BOARD OF OCCUPATIONAL THERAPY EXAMINERS**

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**PROFESSIONAL RECOMMENDATION FORM**

**This Professional Recommendation Form must be completed, signed and submitted by a licensed Medical or Medical Service Professional.**

(PLEASE PRINT OR TYPE)

*The applicant portion of this form should be completed by the individual who is seeking an Occupational Therapist, Occupational Therapy Assistant license or a Limited Permit.*

**1. APPLICANT**

Name: \_\_\_\_\_ (\_\_\_\_\_)  
First Middle Initial Last Other Names Used

Mailing Address: \_\_\_\_\_  
Street Address Apt# City State Zip Code

National Board for Certification in Occupational Therapy (NBCOT) certification number: \_\_\_\_\_

*The remaining portion of this Professional Recommendation Form must be prepared, signed and personally dated by the Medical Service Professional submitting the form on behalf of the applicant.*

**2. MEDICAL OR MEDICAL SERVICE PROFESSIONAL**

a. Please provide the following information:

(1) Where the person making the recommendation worked with the applicant.

\_\_\_\_\_  
\_\_\_\_\_

(2) A written narrative describing the professional relationship or professional experience with the applicant and why they recommend **OR** do not recommend the applicant for an Occupational Therapy license:

(a) I do hereby recommend this applicant \_\_\_\_\_ (Provide written narrative).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) I do not recommend this applicant \_\_\_\_\_ (Provide written narrative).

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(3) What is the length of time that you have known this applicant?

\_\_\_\_\_  
Years

\_\_\_\_\_  
Months

(4) What is the length of time you have worked with this applicant?

\_\_\_\_\_  
Years

\_\_\_\_\_  
Months

(5) Would you consider this applicant to be of good moral character?

\_\_\_\_\_  
Yes

\_\_\_\_\_  
No

b. Please provide the following information concerning the Medical or Medical Service Professional completing, signing and submitting this form on behalf of the applicant:

(1) My name and address are:

_____ First Name	_____ Middle Initial or Name	_____ Last Name		
_____ Street Address	_____ Apt/Suite #	_____ City	_____ State	_____ Zip Code

(2) My daytime telephone number is: (       ) \_\_\_\_\_ - \_\_\_\_\_

(3) My professional license or certification title, license or certification number is:

_____ Title	_____ Number
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(4) Name of the State or Federal agency who issued my professional license or certificate is:

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**3. SIGNATURE & DATE SIGNED BY THE MEDICAL OR MEDICAL SERVICE PROFESSIONAL WHO PREPARED AND IS SUBMITTING THIS PROFESSIONAL RECOMMENDATION FORM.**

_____ Signature	_____ Date
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(PLEASE RETURN WITHIN 10 DAYS)  
**NO FAXED FORMS WILL BE ACCEPTED!**